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October 31, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2349–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: CMS-2349-P, Proposed Rule: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010

Dear Dr. Berwick:

The Commonwealth of Massachusetts appreciates the opportunity to submit comments regarding the Proposed Rule: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 (ACA). The Commonwealth was pleased that the eligibility expansions under the ACA were modeled after our successful state reforms of 2006 that have resulted in a health insurance coverage rate of over 98%. Medicaid is a crucial program for low income individuals in Massachusetts and an important component of our health care system and we were especially pleased that the ACA included a nationwide Medicaid expansion.

The Commonwealth would like to express particular support for several items in the proposed rule. The real-time data matching with the "federal hub" will reduce the burden of collecting verifications on both applicants and the state. The Commonwealth is also pleased by the proposal that Medicaid agencies will have the option to continue coverage through the end of a month to stop the coverage gap for individuals who lose Medicaid eligibility before they are able to enroll into an Exchange plan on the first day of the following month. In addition, the use of administrative renewals by states will eliminate the need for members to return annual redetermination forms. This should significantly reduce the "churning" that happens when individuals go on and off Medicaid due to not returning redetermination forms. Finally, it will be useful for state Medicaid agencies to

be able to accept self-attestation of all eligibility criteria (except citizenship and immigration status) while using trusted sources to verify information.

The Commonwealth also has comments on the following sections of the proposed rule:

§ 431.10 Single State Agency

Please clarify the range of public agencies which could perform Modified Adjusted Gross Income (MAGI) and non MAGI eligibility determinations for Medicaid.

Please clarify whether a non public agency could perform such functions as well under contract with a public agency.

Please clarify the extent of Medicaid eligibility determinations that can be performed by the Exchange and other public (or non public agencies.) Could all aspects of a determination be made by such other agencies?

§ 433.10 Availability of FMAP

Please clarify the definition of "Newly Eligible" within §433 to clarify the meaning of "would not have been eligible for Medicaid." Specifically, the ACA excludes an individual from being considered "Newly Eligible" if the individual was eligible for full benefits or Benchmark coverage as of December 1, 2009. Explicitly incorporating this statutory exclusion within the proposed regulatory definition would clarify the definition. Please also clarify whether the standards under the final Benchmark regulation published in 2010 would apply to this determination.

It may be difficult for states to give CMS two years prior notice regarding choice of methodology for determining appropriate FMAP rates and the Commonwealth requests that CMS consider reducing that to one year.

The Commonwealth also requests that CMS consider reducing the required three year minimum timeframe for using a particular methodology to allow for earlier changes if it becomes clear that a particular methodology is not producing accurate results.

§ 435.119 Coverage for Individuals Age 19 or Older and Under Age 65 at or Below 133 Percent FPL

The Commonwealth requests that the proposed rule incorporate the ACA requirement that individuals falling within the new mandatory adult low income group must receive Benchmark benefits unless they are excluded from Benchmark benefits under §1937 of the Act for clarity.

Please clarify the extent to which FFP is available for an individual in the new mandatory adult low income group who is excluded from Benchmark benefits under §1937 or for whom the state chooses to apply full Medicaid benefits.

Please clarify whether Benchmark coverage could be provided to the new mandatory adult low income group through an individual's health insurance plan, with the Medicaid agency paying the premium on behalf of the individual.

§ 435.110 Parents and other caretaker relatives

Please clarify whether an applicant who is a parent who is receiving Transitional Assistance to Needy Families (TANF) would automatically receive Medicaid if the TANF income level was below the Medicaid standard set by the state for parents? If so, can the TANF agency determine eligibility presumptively for this group under the ACA provision which allows for presumptive eligibility for parents and caretaker relatives?

§ 435.403 Residency Definition for Children (Under Age 21)

Please clarify whether at state option, for the in-state residency determinations, a resident could include a child who attends school out of state.

Please clarify whether the child's age for purposes of an in-state residency determination would be at state option up to a specified limit.

§ 435.603 Application of modified adjusted gross income (MAGI)

Regarding the one month lump sum income proposed rule, could you please clarify this rule in the context of windfall profits such as lottery earnings or large gambling profits?

Please clarify whether the state could have flexibility for applying the one month rule in this context – where there is a concern with shielding large windfall profits?

Could you please clarify the meaning of "living with" in the context of the non-filer household composition rule? Could the state have flexibility to determine the meaning of this in the context of students and other situations?

Please clarify whether an elderly parent/caretaker could be subject to a MAGI determination along with other household members in determining that parent/caretaker's eligibility. Please clarify whether the state could have the option to apply MAGI or non MAGI to such an elder parent/caretaker.

Please clarify which scholarship and fellowship grants would continue to be excluded from income.

Please clarify how to determine the current household. Specifically, would dependents who are claimed on the filed tax return be used (this refers to a prior year household) or would dependents who are claimed currently for tax withholding purposes with an employer be used?

Please confirm whether there could there be any flexibility in the household composition rule in the case where an applicant is under age 21, not a minor and living with his/her parents. Specifically, in the situation where there is an issue concerning confidentiality for urgent health issues of the non-minor and where there is also a concern of abuse if the parents were made aware of the Medicaid application. Would it be possible for the non-minor applicant to apply as a separate household?

Please clarify whether 1115 demonstration waiver and home and community based services waiver populations are subject to MAGI.

One files a tax return to report income from a prior year. Therefore, income amounts and MAGI from tax returns refer to prior year income. Please clarify the use of MAGI from the prior year return and the use of current income data (such as wage reporting in the current year) and how the two sources of income would be utilized to arrive at MAGI for the year of application or redetermination.

If a divorced father (with income over 133% FPL) is claiming a child as a tax dependent and the child lives with the mother (with income under 133%), how is eligibility determined? Would the father be found eligible for a federal tax credit for himself and the child or would the mother be found eligible for Medicaid for herself and the child?

§ 435.907 Application

Please clarify whether the single, stream lined application form is required for Medicaid 1115 demonstration waiver programs.

§ 435.911 Determination of eligibility

Please clarify the proposed regulation §435.911 at (c)(1) which does not clearly include parents in the initial MAGI determination at (c)(1). Also, the regulation requires the prompt furnishing of Medicaid benefits after the initial MAGI determination, without specifying an evaluation as to whether the applicant would fall within the new low income group or a traditional mandatory pregnant, parent or child group first. This additional determination is relevant when these traditional mandatory groups provide a different or full Medicaid benefit package other than Benchmark. Further, it is unclear at what point in the process a MAGI evaluation for the new optional high income group would take place under this regulation.

The proposed regulations consolidate mandatory and optional pregnancy categories. In applying §435.911, would this new consolidated pregnancy standard be treated as a mandatory group that could not fall within the new mandatory adult group? Please clarify.

This regulation at (c)(2) requires other non MAGI determinations in the event the applicant is not eligible under (c)(1). Please clarify this further. If an applicant under age 65 self identifies as disabled, or any other non MAGI category, please discuss the sequence of the MAGI and non MAGI determination. This is relevant in particular where different benefit packages apply to disabled and other non MAGI coverage types. Also, please clarify how this rule would apply to an under age 65 applicant whose income is between 100 and 133 % FPL and could be eligible under the State's Home and Community Based waiver.

Also, the regulation does not provide for time standards for initial and subsequent determinations.

Please clarify these issues regarding proposed regulation §435.911.

§ 435.916 Periodic redeterminations of Medicaid eligibility

The Commonwealth requests that CMS extends the administrative renewal procedure to non MAGI populations but at state option as to which non MAGI populations to apply this procedure.

Please confirm that the Medicaid agency need not require a signature during any portion of the redetermination process.

Please clarify the rules for determining projected annual income for the current year for a current member and provide examples of how this would be used in the context of a redetermination.

§ 435.940-.956 Verification of Income and Other Eligibility Criteria

Please clarify when self attestation is acceptable for income. For example if IRS and state Department of Revenue quarterly wage data is not consistent with what the applicant states does the applicant need to provide verification or not?

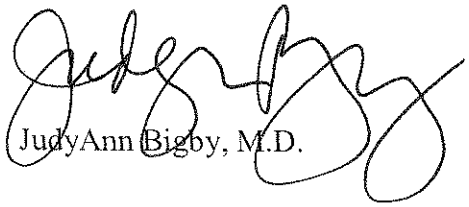
Please also clarify the definition of "*reasonably compatible*" in the sentence in 435.945(b),"Additional information, including paper documentation, can be requested when electronic data source information cannot be obtained or is not reasonably compatible with information submitted by the individual."

Please clarify whether the use of electronic data matches removes the requirement on applicants to verify identity.

The Commonwealth requests that the requirement regarding Social Security numbers be modified for those who would not be eligible for such numbers. This would include lawfully residing children who became eligible for federally funded coverage under the reauthorization of the Children's Health Insurance Program. The requirement to apply for such a number creates an administrative expense and applicant burden when such applicants would not be eligible for a social security number.

We look forward to working with you as we continue to implement the provisions of the Affordable Care Act in Massachusetts and move towards a nationwide system of more affordable and comprehensive health insurance for all.

Sincerely,



JudyAnn Bigby, M.D.